DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 1

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: ~~FEBRUARY 1, 2004~~, March 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 433.51

7. FEDERAL BUDGET IMPACT: 3,830,045
a. FFY 04 $ ~~15,554,690.00~~
b. FFY 05 $ ~~26,648,042.00~~ 6,565,767

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pg 1 & 1a + 1b + 1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pg [redacted]

10. SUBJECT OF AMENDMENT:
Reimbursement-practioner services provided by public entities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Paul Reinhart, Deputy Director
for Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Paul Reinhart

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Deputy Director

15. DATE SUBMITTED: 2/11/2004

16. RETURN TO:
Medical Services Administration
Program Policy-Federal Liaison Unit
400 South Pine St. - 7th Floor
Lansing, MI 48933
ATTN: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/13/04

18. DATE APPROVED: 9/21/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 03/01/04

20. SIGNATURE OF REGIONAL OFFICIAL:
for Harris

21. TYPED NAME: **Cheryl A. Harris**

22. TITLE: **Associate Regional Administrator**
Division of Medciaid and Children's Health

23. REMARKS:
Michigan (04-01)
Approved: 09/21/04
effective: 03/01/04

RECEIVED
FEB 13 2004
DMCH - IL/BRANCH

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

1. Individual Practitioner Services

Payment rates are established by the Medical Services Administration as a fee screen for each procedure. The fee schedule is designed to enlist the participation of an adequate number of providers. The Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVS) and other relative value information, other state Medicaid fee screens, and providers' charges may be utilized as guidelines or reference in determining the maximum fee screens for individual procedures. The state assures that both public and private providers are paid under the same fee screens for the same services. These fee screens are updated and published on a regular basis.

These payment rates apply to the following practitioners:

- Physicians (MD and DO) – Up to 100% of fee schedule
- Ophthalmologists – Up to 100% of fee schedule
- Oral Surgeons – Up to 100% of fee schedule
- Podiatrists – Up to 100% of fee schedule
- Physician's Assistants – Up to 100% of fee schedule except assistant at surgery at 85% of fee schedule
- Nurse Practitioners – Up to 100% of fee schedule except assistant at surgery at 85% of fee schedule
- Certified Nurse Midwives – Up to 100% of fee schedule
- Certified Registered Nurse Anesthetists – Up to 100% of fee schedule for non-medically directed, 50% of fee schedule for medically directed
- Optometrists – Up to 100% of fee schedule

For beneficiaries with no Medicare or commercial insurance coverage, providers are reimbursed the lesser of:

- the Medicaid fee screen minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.
- the provider's usual and customary charge minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.

For beneficiaries with Medicare and/or commercial insurance coverage, providers are reimbursed the lesser of:

- the Medicaid beneficiary's liability for Medicare/commercial insurance coinsurance, co-payments, and/or deductibles minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.
- the Medicaid fee screen minus any third party payments, contractual adjustments, and any applicable Medicaid co-payment, patient pay, or spend-down amounts.

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- the provider's usual and customary charge minus any third party payments, contractual adjustments, and any applicable Medicaid co-payment, patient pay, or spend-down amounts.

A provider's customary charge refers to the amount which the individual practitioner charges in the majority of cases for a specific medical procedure exclusive of token charges for charity patients and substandard charges for welfare and other low income patients.

Payment adjustments will be made for practitioner services provided through the following public entities:

- University of Michigan Health System
- Wayne State University
- Hurley Hospital
- Michigan State University

Adjustments apply to dates of service on or after March 1, 2004. Eligibility for these adjustments is limited to individual practitioners or practitioner groups designated by the public entities. Service provided by the following practitioners, when not included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral Surgeons
- Dentists
- Podiatrists
- Physician's Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Optometrists

Adjustments apply to both public and private practitioners and practitioner groups. Practitioners and practitioner groups are either employees of the public entity or are under a contract with the public entity. All services eligible for the payment adjustment are billed under the federal employer number of the public entity or under the employer identification number of the practitioner/practitioner group. Billings are submitted by the public entity or by the practitioners/ practitioner groups. The Medical Services Administration must concur with the public entity's designations in order for the payment adjustment to be applied.

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The payment adjustment will be the lesser of:

- The difference between the practitioner fee-for-service (FFS) Medicaid fee screens and the allowed amount established by Medicare.
- The difference between the practitioner FFS Medicaid fee screens and the practitioner's customary charge.

Services to beneficiaries enrolled in Medicaid Managed Care Organizations (MMCOs) are not included in the payment adjustments. No provider will receive payments that in aggregate exceed their customary charges.

The entire benefit from this payment adjustment will be retained by the practitioner/ practitioner group receiving the payment adjustment as an offset to incurred public expenditures.

Practitioners will receive a base payment equal to the FFS payment to other practitioners when they bill for services. For each fiscal quarter, the public entity will provide a listing of the identification numbers for their practitioners/ practitioner groups that are affected by this payment adjustment to the MSA. The MSA will generate a report, which includes the identification numbers and utilization data for the affected practitioners/ practitioner groups. This report will be provided to the public entity. The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, the MSA will approve the payment adjustments. The payment adjustments will be made for each fiscal quarter. The process includes a reconciliation that takes into account all valid claim replacements affecting claims that were previously processed.

After the MSA confirms the accuracy of the payment adjustments, the MSA will provide the federal share and the adjustments will be sent to the practitioners/ practitioner groups through the identification number used to bill Medicaid under the FFS program.

The MSA collaborates with the Public Health Administration (PHA) on a Vaccine Replacement Program (VRP). Vaccines are provided free to enrolled Medicaid providers on a replacement basis to immunize Medicaid beneficiaries. Providers are reimbursed an enhanced administration fee to encourage their participation. The MSA reimburses the PHA the government contract price for each dose of vaccine administered, in addition to a per dose handling fee and spoilage allowance. Providers may also request the manufacturer's cost of vaccine if they elect not to participate in the VRP. The department establishes the reimbursement rate for purchased vaccine by allowing the lowest most commonly available cost to purchase the product in multiple dose units plus a nominal administration fee.

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2. Drug Product Reimbursement

a) Reimbursement for drug products is the lower of an Average Wholesale Price (AWP) minus discounts, a Maximum Allowable Cost (MAC), or the provider's charge. The discount from AWP for chain pharmacies and pharmacies with no retail customers serving long term beneficiaries is 15.1% and the discount from AWP for independent pharmacies, including chains of fewer than five stores, is 13.5%

b) The State has established dispensing fees. Program reimbursement is the lesser of the standard dispensing fee ($3.77) or the pharmacy's usual and customary fee. The dispensing fee for standard compounds is $6.00 and $10.00 for compounding capsules and suppositories. Long term care pharmacies are paid 3 cents per capsule or tablet for repackaging.

c) MAC Limits set by the State in aggregate are equal to or less than Federal Upper Limits, in compliance with federal law.

d) Prior authorization is required for exception to MAC Limits.